Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN9008	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A Licensure survey was conducted from July 15, 2013, through July 17, 2013, at Lakebridge Health Care Center. No deficencies were cited in relation to 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

Nyda Pace — Administrator — 7/24/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 5OLV11 If continuation sheet 1 of 1

JUL 25 2013

JUL 24 2013